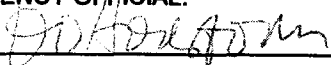



TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: <u>0 1 - 0 0 3</u>	2. STATE: Pennsylvania
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
5. TYPE OF PLAN MATERIAL (Check One): <input checked="" type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT		4. PROPOSED EFFECTIVE DATE January 1, 2001	
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION:		7. FEDERAL BUDGET IMPACT: a. FFY <u>01</u> \$ <u>154,818</u> b. FFY <u>02</u> \$ <u>230,209</u>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1A, pages 4g and 4h Attachment 3.1B, page 4f		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 3.1A, pages 4g and 4h Attachment 3.1B, page 4f	
10. SUBJECT OF AMENDMENT: Payment for dental services.			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Review and approval <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED authority has been delegated to the <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL Department of Public Welfare			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Commonwealth of Pennsylvania Department of Public Welfare Office of Medical Assistance Programs P.O. Box 8043 Harrisburg, PA 17105-8043	
13. TYPED NAME: Feather O. Houstoun			
14. TITLE: Secretary of Public Welfare			
15. DATE SUBMITTED: 1/29/01			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: February 2, 2001		18. DATE APPROVED: May 3, 2001	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2001		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: CLAUDETTE V. CAMPBELL		22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR DIVISION OF MEDICAID & STATE OPERATIONS	
23. REMARKS: J150 1/10/01 J1170			

SERVICE	LIMITATIONS
<u>Dental Services</u>	<p><u>Limitations on payment</u> – Limited to all medically necessary dental services for recipients eligible for EPSDT services.</p> <p><u>Limitations on payment</u> – The following limits apply to payment for compensable services:</p> <ol style="list-style-type: none">(1) Orthodontic services required to treat acute dental problems or prevent irreversible damage to the teeth or supporting structures.(2) Maximum allowance for any combination of dental radiographs per patient per dentist per year is \$69.00.(3) Payment for an initial oral examination is limited to one (1) per patient per dentist.(4) Payment for a periodic oral examination is limited to one (1) per 180 days.(5) Payment for intraoral radiography, complete series, including bitewing, is limited to one (1) per five (5) years.(6) Payment for panoramic-maxilla or mandible, single film is limited to one (1) per five (5) years.(7) Payment for dental prophylaxis is limited to one (1) per 180 days.(8) Payment for space maintainers is limited to one (1) per quadrant.(9) Prior authorization is required for orthodontia, complete and partial dentures, space maintainers, crowns, extraction of more than one tooth in preparation of the insertion of a prosthetic device the extraction of six or more teeth during one visit or one period of hospitalization and all surgical extractions.(10) The maximum allowable payment to a dentist for outpatient surgical procedures per recipient per day is \$500.00.(11) The maximum allowable payment to a dentist per recipient per hospitalization is \$1000.00.(12) Payment for two or more surgical procedures performed by the same dentist is limited to 100% of the allowable fee for the highest paying procedure and 25% of the second highest paying procedure.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE COMMONWEALTH OF PENNSYLVANIA
DESCRIPTIONS OF LIMITATIONS

ATTACHMENT 3.1A
Page 4g

SERVICE	LIMITATIONS
10. <u>Dental Services</u>	<p><u>Limitations on payment</u> – The following limits apply to payment for compensable services for recipients under 21 years of age.</p> <p>(1) Orthodontic services required to treat acute dental problems or prevent irreversible damage to the teeth or supporting structures.</p> <p>(2) Maximum allowance for any combination of dental radiographs per patient per dentist per year is \$69.00.</p> <p>(3) Payment for an initial oral examination is limited to one per patient per dentist.</p> <p>(4) Payment for a periodic oral examination is limited to one per 180 days.</p> <p>(5) Payment for intraoral radiography, complete series, including bitewings, is limited to one per five years.</p> <p>(6) Payment for panoramic-maxilla or mandible, single film is limited to one per five years.</p> <p>(7) Payment for dental prophylaxis is limited to one per 180 days.</p> <p>(8) Payment for space maintainers is limited to one per quadrant.</p> <p>(9) Prior authorization is required for orthodontia, complete and partial dentures, space maintainers, crowns, extraction of more than one tooth in preparation for the insertion of a prosthetic device, the extraction of six or more teeth during one visit or one period of hospitalization and all surgical extractions.</p> <p>(10) The maximum allowable payment to a dentist for outpatient surgical procedures per recipient per day is \$500.00.</p> <p>(11) The maximum allowable payment to a dentist per recipient per hospitalization is \$1,000.00.</p> <p>(12) Payment for two or more surgical procedures performed by the same dentist is limited to 100% of the allowable fee for the highest paying procedure and 25% of the second highest paying procedure.</p>

TN# 01-003
Supersedes
TN# 99-015

Approval Date MAY 3 2001

Effective January 1, 2001

SERVICE	LIMITATIONS
10. <u>Dental Services (continued)</u>	<p><u>Limitations on payment</u> – The following limits apply to payment for compensable services for recipients 21 years of age and older.</p> <p>(1) Payment for oral examination is limited to one per 365 days.</p> <p>(2) Payment for dental prophylaxis is limited to one per 365 days.</p> <p>(3) Payment for root canal requires a post-operative review.</p> <p>(4) Payment for crown coverage is limited to one crown per tooth per six years.</p> <p>(5) Payment for denture relines, either full or partial, is limited to one per arch, every two years.</p> <p>(6) The maximum allowance for any combination of dental radiographs per patient per dentist per year is \$69.00.</p> <p>(7) Payment for panoramic-maxilla or mandible, single file is limited to one per five years.</p> <p>(8) Prior authorization is required for complete and partial dentures, crowns and the extraction of six or more teeth during one visit or one period of hospitalization and all surgical extractions.</p> <p>(9) The maximum allowable payment to a dentist for outpatient surgical procedures per recipient per day is \$500.00.</p> <p>(10) The maximum allowable payment to a dentist per recipient per hospitalization is \$1,000.00.</p> <p>(11) Payment for two or more surgical procedures performed by the same dentist is limited to 100% of the allowable fee for the highest paying procedure and 25% of the second highest paying procedure.</p>